St. Vincent Health
Where caring and community meet

Financial Assistance Policy

St. Vincent Health Hospital & Clinic

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at St. Vincent Health hospital or clinic, for one calendar year from date of issue. The business office can provide you with further details. Please contact the Business office at 719-486-7157 with any questions.

Please provide the following:

Employed	Self Employed
• Tax Returns for previous year ***or*** • 2 current pay stubs from last calendar month for patient or spouse ***or*** • 1 month bank statement showing income • Proof of ID for patient/guarantor: Choose 1 from this group: Passport, State, Federal or other Country issued Photo I.D. or Green Card, School ID, Medicaid or CHP+ card. And • Second Form of ID Choose 1 from this group: SS card, Birth Certificate, Visa, rent, utility receipts, etc.	• One Month of gross bank business deposits. • Year-to-date- profit and loss statements or business ledgers • Business taxes from previous year

If you are homeless please ask to speak to our Eligibility Coordinator

Provide proof of earned income if applicable:

- Unemployment
- Worker's Compensation
- Social Security or Supplemental
- Security SSI
- Public Assistance
- Veteran's Benefits
- Disability Benefits
- Pensions or Retirement
- Interest or Dividends
- Rents, Royalties, estates and trusts
- Alimony
- Survivor Benefits

INCOME:

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children Under age 18			
Total:			

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, Interest, dividend, and other income				
Total Income				

HOUSEHOLD:

Number of related persons living in your households: _____

Name of Head of Household	Place of Employment			
Street	City	State	Zip	Phone
Health Insurance Plan	Social Security			

Name	Date of Birth	Name	Date of Birth
Self		Dependent (under 18 years of age)	
Spouse		Dependent (under 18 years of age)	
Dependent (under 18 years of age)		Dependent (under 18 years of age)	
Dependent (under 18 years of age)		Dependent (under 18 years of age)	

If more space is needed add names and dates of birth below:

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) _____ Date _____

Signature _____

2026 HHS POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES

Federally facilitated marketplaces will use the 2026 guidelines to determine eligibility for Medicaid.

Number of Persons in Household	0-150%	151 – 299%	300 – 399%
1	$0.00 – $23,940	$23,941 - $47,720	$47,721 – $63,680
2	$0.00 – $32,460	$32,461 - $64,703	$64,704 – $86,343
3	$0.00 – $40,980	$40,981 – $81,686	$81,687 – $109,006
4	$0.00 – $49,500	$49,501 – $98,670	$98,671 – $131,670
5	$0.00 - $58,020	$58,021 – $115,653	$115,654 – $154,333
6	$0.00 – $66,540	$66,541 – $132,636	$132,637 – $176,996
7	$0.00 – $75,060	$75,061 – $149,619	$149,620 - $199,659
8	$0.00 – $83,580	$83,581 – $166,602	$166,603 – $222,322

ADJUSTED FEDERAL POVERTY LEVEL	PATIENT RESPONSIBILITY (INPATIENT, OBSERVATION)	PATIENT RESPONSIBILITY (OUTPATIENT RECURRING, PHYSICIAN SERVICES, PHYSICAL THERAPY)	PATIENT RESPONSIBILITY (EMERGENCY)	PATIENT RESPONSIBILITY (LAB, Radiology, Screenings/Diagnostic)	ADJUSTMENT
0–150%	0% of charges	0% of charges	0% of charges	0% of charges	100%
151–299%	20% of charges	20% of charges	20% of charges	20% of charges	80%
300–399%	30% of charges	30% of charges	30% of charges	30% of charges	70%